U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 July 2007

In the Matter of:

H.B.,
Claimant

Case No.: 2004-BLA-6474

v.

AHN TRUCKING COMPANY, INC.,
Employer

and

EMPLOYER INSURANCE OF WAUSAU,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Joseph E. Wolfe, Esq.
Wolfe, Williams, & Rutherford
Norton, Virginia
For the Claimant

H. Ashby Dickerson, Esq.
Penn Stuart
Abingdon, Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death

was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on April 5, 2006, in Hazard, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director of the Office of Workers Compensation Programs (OWCP) was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") 20-40. Director's Exhibits ("DX") 1-39, Claimant's Exhibits ("CX") 1-4 and Employer's Exhibits ("EX") 1-16 were admitted into evidence without objection. Tr. 6-7, 7-11, and 11-14 . EX 17 was excluded because it was not listed in the Employer's Evidence Summary Form, and because it appeared to be a rebuttal reading of an x-ray taken during treatment.[1] Tr. 13. The record was held open after the hearing to allow the parties to submit additional evidence and argument. EX 18, treatment records of Dr. Bielecki (excluding Form CM-988, which is not a treatment record), was admitted into the record in an Order dated June 22, 2006. The Claimant and Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence unless otherwise noted, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on July 6, 1995. DX 1 at 333. The claim was denied by Administrative Law Judge Daniel Sutton in a Decision and Order issued September 5, 1997. DX 1 at 3. Judge Sutton determined that the evidence did not establish the Claimant suffers from pneumoconiosis. He also found that the Claimant was totally disabled by a pulmonary or respiratory impairment, but that the Claimant had not established that it was caused by pneumoconiosis.

The Claimant filed his current claim on February 12, 2003. DX 3. The Director issued a proposed Decision and Order awarding benefits on March 11, 2004. DX 31. The Employer appealed on March 31, 2004. DX 32. The claim was referred to the Office of Administrative Law Judges for hearing on June 29, 2004. DX 37.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on February 12, 2003. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the

[1] Review of the file discloses that there were two x-rays taken on April 16, 2003, one in connection with treatment, and another in connection with the Department of Labor examination. *See* the table of x-ray readings below. The reading by Dr. Scatarige was properly excluded, either because it was an impermissible rebuttal reading of a treatment x-ray, *see Henley v. Cowing & Company, Inc.*, BRB No. 05-0788 BLA (May 30, 2006) (unpub.), or because it exceeded the limitations for rebuttal readings of the Department of Labor x-ray found in 20 CFR § 725.414.

current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether his disability is due to pneumoconiosis.

DX 37; Tr. 5. At the hearing, the Employer withdrew the issues of timeliness of the claim, whether the Claimant was a miner, whether he had post 1969 coal mine employment, and whether it was properly named as the responsible operator. Tr. 5. In addition, the Employer stipulated to 11 years of coal mine employment, the number of years found by Judge Sutton. Tr. 5-6. The Employer implied that it wished to withdraw the stipulation in its Closing Argument at 3. I find that the Employer is bound by the stipulation. The Employer also impliedly raised an additional issue in the brief by stating that "[t]here may also be an issue concerning dependency" because there was evidence in the file that the Claimant's wife is not dependent on him. Closing Argument at 3. Dependency was not marked as an issue on the CM-1025, DX 37, nor was it raised at hearing. I find that this issue was waived. Whether the Claimant is disabled was marked on the CM-1025 as being at issue, but the issue of whether there has been a change in one of the applicable conditions of entitlement was not. DX 37. In its Closing Argument at 2-3, the Employer conceded both issues.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the hearing on April 5, 2006, and at the hearing on his previous claim on July 25, 1997, *see* DX 1 at 16 et seq. He was almost 65 years old at the time of the 2006 hearing. Tr. 31.

The Claimant alleged over 20 years of coal mine employment. *See* DX 4, DX 5, DX 6. The Employer stipulated that the Claimant had 11 years of coal mine employment. The

Claimant's last coal mine related employment was with AHN Trucking, where he drove a truck hauling coal. The Claimant testified at the 1997 hearing that he worked for AHN Trucking full time, as an employee and an independent contractor. This is consistent with his Social Security earnings records, showing income from AHN and self-employment during the relevant years. The Claimant identified other coal mine employers, and said his Social Security records correctly reflected his earnings from those employers. Crediting the Claimant's testimony, based on the Social Security records, DX 7, I find that the Claimant had 11 years of coal mine employment. According to the Claimant, he was exposed to coal dust in his job with AHN. He stated the cab of this truck was covered with coal dust and dirt. Tr. 21-22. *See also* DX 1 at 30. Prior to working for AHN Trucking, he worked for Bentley Coal Company. There, he worked underground shoveling coal into cars. Tr. 26. He stopped working in 1995. DX 7. His last coal mine employment was in Kentucky. DX 4, DX 6. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

On cross-examination at the 2006 hearing, the Claimant was asked about his smoking history. Asked whether he has ever been a smoker, he said he smoked a little when he was young, but never had a habit of it. Asked whether that is what he told his doctors, he said that was true of all except Dr. Fritzhand, who got mixed up and put down the wrong thing when he told him he smoked a pack or a pack and a half when he was smoking. Tr. 30. He said he thought that Dr. Fritzhand's report was sealed. Tr. 31. He said that Dr. Bielecki has been his family doctor for the past 20 to 25 years. He did not recall that Dr. Bielecki had ever taken a smoking history. Tr. 32. When shown a progress note from Dr. Bielecki dated August 3, 1995, indicating that he smoked a pack and a half a day from age 17 to 50, having quit 3 or 4 years before, he denied having given her such a history. Tr. 33-34, 35. He was generally argumentative with counsel when confronted about how much he smoked; he repeatedly said that if he had been smoking as much as claimed, he would have to have been smoking before he was even born. *See* Tr. 31-35. Asked whether he had ever told any doctors that he never smoked, he said he told them he "smoked some, but not a whole lot. I never was hooked on it." Tr. 40. The Claimant was not asked about his smoking history at the 1995 hearing.

Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The burden of proof is on the Claimant on this issue, but the issue may be waived by the Employer. 20 CFR § 725.309(d) (2006).[2] In this case, although Judge Sutton found that the Claimant was totally disabled, Decision and Order at 11, DX 1 at 13, the Employer conceded in its post-hearing brief that a change of conditions has occurred on the basis of the new medical opinion evidence establishing that the Claimant is totally disabled. Employer's Closing Argument at 2-3. I construe this concession to constitute a waiver, and have therefore addressed all of the medical evidence in the record from both claims. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2006). 20 CFR § 725.309(d)(1) (2006). Moreover, no findings in the prior claim are binding,

[2] 20 CFR § 725.309(d) provides in pertinent part, "the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator …"

unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2006).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column. X-ray readings exceeding the limitations do not appear on the table. *See* notes 4 and 5 below.

Physicians' qualifications appear after their names. Qualifications of physicians who read x-rays in connection with the black lung claims have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[3] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B=

[3]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM . Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org. The parties were notified at the hearing that I proposed to take judicial notice of physician qualifications listed on the Internet by these organizations, and had no objection to my doing so. Tr. 19.

NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
07/19/95		DX 1 Sargent BCR/B DX 1 Halbert BCR/B DX 1 Wiot B DX 1 Spitz B DX 1 Shipley B DX 1 Broudy B DX 1 Jarboe ILO Classification 0/1 DX 1 Dineen B DX 1 Wheeler BCR/B DX 1 Scott BCR/B DX 1 Fino B DX 1 Homlar B	
10/03/95	DX 1 Myers A ILO Classification 1/0		
11/01/95	DX 1 Baker B ILO Classification 1/0		

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/29/95		DX 1 Sargent B/BCR DX 1 Wiot B DX 1 Spitz B DX 1 Shipley B DX 1 Broudy DX 1 Jarboe ILO Classification 0/1 DX 1 Dineen DX 1 Wheeler BCR/B DX 1 Scott BCR/B DX 1 Fino B DX 1 Homlar B	
04/21/01			CX 1 Hashem Emphysema. Pneumonia.
04/22/01			CX 1 Hashem Pneumonia
04/23/01			CX 1 Kabir Persistent consolidation.
04/24/01			CX 1 Kabir Persistent consolidation.
04/26/01 (2 x-rays)			CX 1 Kabir Persistent consolidation. CX 1 Kabir Pneumonic infiltrate.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/29/01 (2 x-rays)			CX 1 Bogner No significant change. CX 1 Hashem Pneumonia unchanged.
04/30/01			CX 1 Hashem Pneumonia unchanged.
05/01/01			CX 1 Hashem Infiltrates without improvement.
05/02/01			CX 1 Hashem Infiltrates without improvement.
05/07/01			CX 1 Kabir Persistent consolidation and atelectasis in right lung
05/13/01			CX 1 Kabir No definite interval change.
05/16/01			CX 1 Hashem Extensive pneumonia.
05/28/01			CX 1 Hashem Right lower lobe infiltrate with consolidation showed partial resolution. Underlying neoplasm cannot be excluded.
11/11/02			CX 1 Bognar Emphysema. Right perihilar infiltrate

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
01/08/03			EX 13 Illegible Interstitial scarring lower lung fields. Emphysema. Possible pneumonitis.
03/30/03			CX 1 Buck Chronic interstitial changes in right lobe. Emphysema. No focal infiltrates.
04/01/03			DX 12 Buck Interstitial changes and emphysema.
04/16/03[4]		**DX 12 Patol BCR ILO Classification 0/1 EX 2 Scott BCR/B**	**DX 13 Barrett BCR/B Read for quality only. Quality 1 (Good)**
04/16/03			CX 1 Buck Emphysema. Pneumonia.
04/17/03			CX 1 Buck Emphysema. Improving infiltrate.
05/06/03			CX 3 Pampati COPD. Congestive failure changes noted.
10/07/03			CX 1 Buck Mild congestive heart failure and emphysema.
10/27/03		**DX 14 Poulos BCR/B**	

[4] As noted above, a re-reading by Dr. Scatarige of either this, or the next-listed x-ray taken this same day, found in EX 17, was excluded from evidence.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/07/04			CX 1 Buck Infiltrate suggestive of mild cardiac failure. Emphysema.
04/10/04			CX 1 Buck Emphysema. Resolution of congestive failure and infiltrates.
04/21/04			CX 1 Buck Severe interstitial change and severe emphysema.
06/01/04			EX 8 Buck Infiltrate in both lungs.
06/03/04			EX 8 Buck Infiltrate in left lung.
09/11/04			EX 4 Buck Emphysema and chronic interstitial changes.
11/05/04		**EX 1 Wiot BCR/B**[5]	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-33-1-34 (1991).

The record in this case contains reports of three CT scans of the Claimant's chest taken during treatment. The results appear on the following table.

[5] The Employer also submitted a negative reading of this x-ray by Dr. Fino. EX 1. It exceeds the limitations on medical evidence, and I have not considered it.

Exhibit #	Date of CT	Reading Physician	Interpretation or Impression
CX 1	05/16/01	Hashem	Extensive right lower lobe pneumonia with consolidation and mediastinal lymphadenopathy.
EX 12	01/08/03	Illegible	Minimal interstitial fibrosis at lung bases. Severe bullous emphysematous changes. No focal pulmonary lesions.
CX 1	04/22/04	Buck	Emphysema and chronic interstitial changes. COPD.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction or restriction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 07/19/95 Fritzhand	54 73"	1.5	3.4	44%	53.4	Yes	Severe COPD. Invalidated by Dr. Kraman, DX 1 at 294.

[6] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 70" to 74", I have taken the mid-point (72") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 09/08/95 Fritzhand	54 73”	1.5 1.6	3.5 3.8	43% 42%	52.1 46.9	Yes Yes	Invalidated by Dr. Kraman, DX 1 at 292.
DX 1 10/03/95 Myers	54 73”	1.51 1.60	3.36 4.03	45% 40%		Yes	Severe obstruction.
DX 12 04/16/03 Alam		3.84 1.20	4.82 4.26	80% 28%		No Yes	No tracings included or data. Invalid per Dr. Long, DX 14.
CX 1 04/18/03 Alam	62 72”	1.44	3.03	48%		Yes	Severe obstruction, low vital capacity possible from a concomitant restrictive defect
DX 14 10/27/03 Rosenberg	**62 74”**	**1.38 1.52**	**3.17 3.58**	**44% 42%**	**52 47**	**Yes**	**Severe obstruction. No restriction. Definite bronchodilator response.**
CX 1 04/09/04 Alam	63 70”	1.35	2.77	49%		Yes	Severe obstruction
CX 1 04/22/04 Alam	63 70”	0.79	1.80	44%		Yes	Very severe obstruction.
EX 1 11/05/04 Fino	**63 72”**	**1.70 1.79**	**3.47 3.88**	**49% 46%**		**Yes**	**Moderate obstructive disease. No bronchodilator response.**

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Treatment records and records from the prior claim are not subject to the limitations. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	**Date**	**Physician**	**pCO_2 at rest/ exercise**	**pO_2 at rest/ exercise**	**Qualify?**	**Physician Impression**
DX 1	07/19/95	Fritzhand	39.9	73.7	No	
EX 18	05/14/01	Hospital	46.4	57.0	Yes	
CX 1	03/29/03		42.2	55	Yes	
CX 1	03/29/03		41.6	68	No	
DX 12	**04/16/03**	**Alam**	**44.3**	**47.2**	**Yes**	**Validated by Dr. Burki.**
CX 1	04/16/03		35.1	57.0	Yes	
CX 1	04/17/02		38.9	71.0	No	
CX 1	10/07/03	Hospital	37.7	56.0	Yes	
DX 14	**10/27/03**	**Rosenberg**	**40.6**	**56.9**	**Yes**	**Significant hypoxia at rest.**
CX 1	04/21/04	Hospital	45.0	67.0	No	

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
EX 1	**11/05/04**	**Fino**	**44.8** **43.7**	**66.4** **58.9**	**No** **Yes**	**Hypoxemia at rest and with exercise.**

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to this case.

Treatment Records

The Employer submitted treatment records from Dr. Marlene Bielecki from August 3, 1995, to February 13, 2006. EX 18. Parts of Dr. Bielecki's records were also included in other exhibits. According to the web-site of the American Board of Medical Specialties, Dr. Bielecki is board certified in Family Medicine. Dr. Bielecki's progress notes reflect that she treated to Claimant for multiple medical problems. In this decision, I have addressed only the conditions relevant to the black lung claim.

The Claimant first visited Dr. Bielecki on August 3, 1995, as a walk-in patient. The Claimant was 54 years old. He complained of breathing problems for the past 3 or 4 years. He told Dr. Bielecki that he had recently been laid off from his job of 18 years as a coal truck driver. He complained of a chronic productive cough. He reported smoking a pack and a half a day from the age of 17, to approximately age 50, having quit smoking 3 or 4 years before the visit. Before visiting Dr. Bielecki, the Claimant had only seen a doctor once in his life. Chest examination revealed faint scattered wheezes with no rales or rhonchi. He had fairly well

preserved breath sounds. Dr. Bielecki assessed possible black lung. As the Claimant reported that he had recently undergone a chest x-ray and pulmonary function test, among other testing, Dr. Bielecki planned to obtain those reports.[7] When the Claimant returned on August 31, 1995, Dr. Bielecki had not yet received his records, and suggested that he pick them up himself. His lungs revealed diminished breath sounds, with no wheezing, rhonchi or rales. On this visit, Dr. Bielecki assessed COPD (chronic obstructive pulmonary disease) and chronic bronchitis. EX 18.

The Claimant next returned to see Dr. Bielecki on February 20, 1996. She recorded that he quit smoking in 1991. She again assessed COPD. She again requested the Claimant to obtain the results of tests being given in connection with his black lung claim to avoid the need to duplicate tests he was having performed elsewhere. His lungs were clear. EX 18.

A telephone message dated June 11, 1996, recorded that the Claimant had called wanting to know why Dr. Bielecki's office had given his records to the workers compensation lawyers telling them he had smoked for years. The message indicated that the person who took the call told him that he had signed a release, and if he had any questions about Dr. Bielecki's chart notes, he should discuss it with her. EX 18.

When the Claimant returned to Dr. Bielecki's office on August 20, 1996, he apologized, suggesting that the opposing side's lawyer had fabricated some information. Dr. Bielecki referred back to her original progress note, and advised the Claimant that she writes down as honestly as she can what she has been told. As to his then current condition, she noted that he was not smoking, and assessed his COPD as stable. EX 18.

The Claimant returned for routine visits every few months thereafter. His wife almost always accompanied him. On November 4, 1996, his lungs were clear with diminished breath sounds. On January 27, 1997, he reported being more short of breath. The Claimant was unable to afford to fill all of his prescriptions for inhalers. Dr. Bielecki assessed exertional dyspnea, "presumably from his known pneumoconiosis, but patient understands that underlying heart disease could also contribute or other serious lung pathology." On March 24, 1997, in addition to diminished breath sounds, there were scattered rhonchi. The assessment continued to include COPD. Notes from September 8 and November 3, 1997, visits were similar to those from earlier visits. The notes from September stated, "He is not a smoker." On March 18, 1998, the Claimant had a bad chest cold, and Dr. Bielecki assessed bronchitis in addition to COPD. At his following visits on July 7, October 21, and December 2, 1998, Dr. Bielecki described his COPD as "controlled" or "stable." Three 1999 visits resulted in similar reports. Except for a bad head cold reported in January 2000, and another in August 2000, his condition continued to be reported as stable that year as well. On October 30, 2000, Dr. Bielecki reported scattered rhonchi and wheezes, and assessed "long standing COPD – nonsmoker." She said his exertional dyspnea "could be related to his COPD or could be an angina equivalent." The Claimant declined a referral to a cardiologist. EX 11, EX 18.

In 2001, Dr. Bielecki changed from typed to handwritten notes for a few months. Some of the entries are hard to read. It appears that a January visit resulted in typical findings as

[7] It appears that Dr. Bielecki was referring to the Claimant's examination by Dr. Fritzhand in July 1995, in connection with his black lung claim. Dr. Fritzhand's examination is described below.

before. On April 19, 2001, however, his oxygen saturation was recorded as 80%, and he was placed on oxygen and admitted to the hospital. A note dated May 8, 2001, indicates that Dr. Alam had recommended thoracentesis and possible chest tube if the Claimant had empyema. Dr. Bielecki's notes elsewhere indicate that the Claimant did have empyema, and that this was a life-threatening illness, requiring two weeks of mechanical ventilation for respiratory failure. EX 18. The hospital records from that illness are not in evidence.

Dr. Bielecki next saw the Claimant in an office visit on May 24, 2001. She said he looked "remarkably well considering his recent prolonged critical hospitalization for left lower lobe pneumonia and unresolving empyema." His lungs were clear, except diminished at the right base. Breath sounds were diminished in both bases at a follow-up visit on May 31. Another follow-up note from June 14, 2001, is mostly illegible. By June 26, 2001, he was doing very well. His COPD was described as "severe." By August 8, 2001, he was able to give up his home oxygen. On October 3, 2001, he reported having had a chest cold. A chest x-ray on December 7, 2001 suggested possible early lung infiltrates. He had seen a different doctor with a flare up of bronchitis. On January 10, 2002, his lungs revealed diminished breath sounds at the right base and scattered rhonchi and wheezes. Dr. Bielecki did not think a repeat chest x-ray was warranted, but she planned to maximize medication therapy. By February 7, he was breathing better. The assessment included severe COPD and resolved bronchitis. His lung condition remained stable from April through October 2002. According to Dr. Bielecki's November 21, 2002, progress note, the Claimant was hospitalized for pneumonia from November 10-12, 2002, when he insisted on being released. Dr. Bielecki described his x-ray as "grossly abnormal with what appears to be chronic scarring right mid lung"; she did not see much difference from his last baseline and chest x-ray. EX 10, EX 18.

The Claimant was hospitalized with an exacerbation of his COPD in December 2002. Dr. Bielecki's follow-up notes dated January 9, 2003, described a subsequent visit to an emergency room due to abdominal pain, during which the Claimant's abnormal chest x-ray led to a CAT scan and echocardiogram. The Claimant again declined referral to a cardiologist, although Dr. Bielecki explained that some heart symptoms might be masked by his bad lungs. Her assessment included severe bullous emphysema. The Claimant returned to Dr. Bielecki's office on January 22 and 29, 2003, due to an apparent allergic reaction to antibiotics given him for bronchitis in the hospital. EX 9, EX 18.

When the Claimant returned to Dr. Bielecki on March 11, 2003, he once again had a reduced oxygen saturation and was administered supplemental oxygen. His lungs were clear with diminished breath sounds. The assessment was hypoxia. Dr. Bielecki prescribed home oxygen therapy. She preferred at that point to continue to manage the Claimant's blood pressure, and have Dr. Alam focus on the Claimant's lung condition. EX 18.

The Claimant underwent his examination for the Department of Labor on April 16, 2003. DX 12. The examination was performed by Dr. Alam. His report is described below. An x-ray was taken as part of the examination, and read for the Department of Labor by Dr. Patol. Although there is no mention of it in Dr. Alam's report to the Department of Labor, it appears that he diagnosed the Claimant with pneumonia, and admitted him to the hospital that day. *See* the Radiology Reports of x-rays taken the same day and the following day by Dr. Buck, found in CX 1. The records of the Claimant's hospital stay are not in evidence. It appears from Dr. Bielecki's notes, however, that the Claimant was in the hospital for three days.

Dr. Bielecki's notes from a visit on May 6, 2003, indicate that the Claimant had been discharged from the hospital on April 19. His lungs showed diminished breath sounds at the bases. His chest x-ray showed chronic changes, with no obvious acute infiltrate. The assessment included chronic severe COPD. As of July 8, and August 19, 2003, the Claimant continued to do well in general, although hot weather bothered his breathing. He did not qualify for home oxygen. CX 2, EX 18.

The Claimant was hospitalized under the care of Dr. Bielecki from October 7, 2003 to October 10, 2003. The physical examination revealed "moderate wheezing and rhonchi bilaterally. No rales." The initial assessment included COPD exacerbation. In the description of his hospital course in the discharge summary, Dr. Bielecki said he was "currently a nonsmoker." Chest x-ray showed mild congestive heart failure and emphysema. He improved with medication, and by October 10, his breath sounds were clear. The final diagnoses included acute bronchitis exacerbation of COPD, hypoxia, hypertension, and mild congestive heart failure, most likely due to hypoxia and hypertension. CX 1, EX 18.

Dr. Bielecki saw the Claimant in follow-up on October 21, 2003. The Claimant had been doing better, but remained short of breath. Chest examination revealed bilateral rhonchi and faint wheeze, and diminished breath sounds. The assessment was COPD and significant coal mine exposure. Dr. Bielecki said that Dr. Alam felt that the Claimant had coal workers' pneumoconiosis based on his x-ray, appearance, and past medical history. CX 2, EX 18. Dr. Bielecki completed a black lung examination report which was not offered into evidence by the Employer, because it is a medical report within the meaning of 20 CFR § 725.414(a)(1), rather than a treatment record. *See* the letter dated May 4, 2006 from counsel for the Employer.

On December 22, 2003, the Claimant visited Dr. Bielecki because he had developed what he thought were flu symptoms. On examination, he had diminished breath sounds and scattered rhonchi. Dr. Bielecki diagnosed an upper respiratory infection, bronchitis and COPD. CX 1, EX 18. When he returned in January 2004, he was stable. He returned again in February to address his medications for hypertension. EX 16, EX 18.

The Claimant was hospitalized again from April 7, 2004 to April 10, 2004, this time under the care of Dr. Alam. He reported that the Claimant was well known to him as he had seen him on multiple occasions. He said the Claimant was a regular patient of Dr. Bielecki. He described the Claimant as a former smoker who had 10 to 15 years of coal mine employment. The physical examination on admission revealed "minimal rhonchi but no bronchial breathing or dullness to percussion." He improved with medication. The initial and discharge diagnoses were "chronic obstructive pulmonary disease exacerbation, coal worker's pneumoconiosis, left lower pneumonia." CX 1.

The Claimant returned to Dr. Bielecki on April 20, 2004, with increasing shortness of breath after having a head and chest cold for several days. On examination, his lungs showed moderate wheezing. Chest x-ray showed chronic scarring and no acute infiltrates. Dr. Bielecki diagnosed a bronchitis exacerbation of COPD. EX 18.

The Claimant was admitted to the hospital on April 21, 2004 and discharged on April 22, 2004. He came to the hospital complaining of smothering. Dr. Breeding reported that the

Claimant was a non-smoker. Dr. Breeding's initial impression was acute bronchitis and chest pain. The Claimant was admitted for aggressive pulmonary treatment and to rule out myocardial infarction. During his stay, Dr. Garimella of the cardiology service was called for a consultation. She reported that the Claimant had quit smoking 25 years ago and had 15 years of coal mine employment. Her assessment included COPD exacerbation. An echocardiogram showed normal left ventricular function with and ejection fraction around 60%. There was no pulmonary hypertension. A hospital note numbered page 2 of 3, but not identifying which doctor dictated it, said that the chest x-ray showed bilateral emphysema with changes consistent with coal workers' pneumoconiosis, and assessed chronic obstructive pulmonary disease exacerbations with underlying coal workers' pneumoconiosis. CX 1.

The Claimant returned to see Dr. Bielecki on May 4 and 27, 2004. She continued to focus on controlling his hypertension. She added chronic hypoxia to his diagnoses. EX 15, EX 18.

The Claimant was admitted to the hospital again on June 1, 2004. This time he was under the care of Dr. Bielecki. He presented to the emergency room complaining of increasing cough, shortness of breath and fever. He was diagnosed with bilateral pneumonia. While he was in the hospital, Dr. Bielecki sought consultations with Dr. Khater, an infectious disease specialist, and Dr. Roy, a surgeon. The Claimant improved with medication and was discharged on June 5, 2004. EX 5, EX 6, EX 18.

Follow-up with Dr. Bielecki was routine in July 2004, but on September 9, 2004, the Claimant complained of increasing cough, shortness of breath, and increased sputum production. He had been to the emergency room the day before; the doctor there suggested that he be prescribed portable oxygen. Dr. Bielecki described him as mildly dyspneic with conversation. His lungs showed moderate wheezing. Dr. Bielecki diagnosed bronchitis exacerbation of COPD. The Claimant was also having abdominal symptoms. He was admitted to the hospital the following day after ultrasound revealed he had cholecystitis. His severe chronic obstructive pulmonary disease increased his surgical risks. His gall bladder was removed. He did well postoperatively, and did not require ventilator support. He was discharged on September 16, 2004. He was doing well when he saw Dr. Bielecki in follow up on September 27, except for some shortness of breath when he had been exposed to turpentine fumes. Dr. Bielecki recommended that he avoid fumes and passive smoke. EX 14, EX 18.

Dr. Bielecki saw the Claimant again in routine follow-up three times in 2005. His problems were generally stable. The last note from Dr. Bielecki was for a routine follow-up on February 13, 2006. EX 18.

Opinions Given in Connection with the Black Lung Claims

Dr. Martin Fritzhand examined the Claimant on behalf of the Department of Labor on July 19, 1995. DX 1 at 279. According to the web-site of the American Board of Medical Specialties, Dr. Fritzhand is board-certified in urology. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for over 30 years. He reported a smoking history of 1-1 1/2 packs per day from 1960 to 1992. The chest examination revealed an increased A/P diameter, and diminished excursion and chest expansion.

Breath wounds were distant, with not rales, rhonchi or wheezes. Dr. Fritzhand said the x-ray was negative for pneumoconiosis. The pulmonary function test showed severe COPD. The arterial blood gas study did not result in qualifying values. No exercise study was administered because the Claimant said he was too short of breath to exercise. Dr. Fritzhand diagnosed COPD and pneumoconiosis. He said the diagnosis was based on a history of over 30 years of exposure to coal dust rather than on chest x-ray changes. He attributed the Claimant's COPD entirely to cigarette smoking, and pneumoconiosis entirely to exposure to coal dust. Dr. Fritzhand found that the Claimant's pulmonary impairment would prevent him from performing his last coal mine employment.

On December 8, 1995, a Claims Examiner for the Department of Labor wrote to Dr. Fritzhand seeking supplemental information. The Claims Examiner advised Dr. Fritzhand as follows:

> In your physical examination, you diagnosed the existence of pneumoconiosis based on over a thirty (30) year exposure to coal dust rather than on a chest x-ray. As of this date, [the Claimant] has established only 3+ years of coal mine employment. He alleged twenty (20) years of coal mine employment ending in April 1995. According to your medical report, [the Claimant] has a thirty (30) year smoking history of 1 to 1 1/2 packs per day ending in 1992.
>
> …[Two] Board-certified radiologists and B-readers, concluded that the x-ray is negative for coal workers' pneumoconiosis.

DX 1 at 285. The Claims Examiner asked Dr. Fritzhand to consider the new evidence, and comment on whether it was likely that the Claimant had pneumoconiosis. Dr. Fritzhand responded, "Based on the above revised work history, it is unlikely that [the Claimant] has pneumoconiosis." Ibid. Dr. Fritzhand indicated that it is possible to distinguish between a respiratory impairment caused by smoking and one caused by coal dust exposure. Dr. Fritzhand said that despite the variability of the pulmonary function tests, he thought them to be representative of the Claimant's pulmonary function, and those results were the primary reason he felt that the Claimant's pulmonary impairment would prevent him from performing coal mine work. He also said that the findings were more likely seen in COPD than pneumoconiosis, and went on to state, "With the revised work history, all pulmonary symptoms and signs can be attributed directly to COPD i.e. to his smoking history."

Dr. John E. Myers, Jr., examined the Claimant at the request of his counsel on October 3, 1995. DX 1 at 215. According to the web-site of the American Board of Medical Specialties, Dr. Myers is board-certified in internal medicine, and an A reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 36 years, with only 3 or 4 years underground. He reported that the Claimant smoked a little bit as a teen, but had not smoked since the 1960's. The chest examination revealed wheezes with obvious impairment of air exchange. Dr. Myers read the x-ray as showing silicosis, category 1/1, and changes compatible with obstructive airway disease and emphysema. The pulmonary function test showed severe obstructive defect in ventilation without significant improvement with bronchodilators. Dr. Myers said that the Claimant had "significant pulmonary disease of no obvious source other that his dust exposure. He is a non smoker. He has never had pneumonia.

He gives no history of other potentially damaging conditions." DX 1 at 217. Dr. Myers diagnosed coal workers' pneumoconiosis, category 1/1, and chronic obstructive pulmonary disease. He said that the Claimant had silicosis resulting from his history of exposure to coal and rock dust. He said that the Claimant falls into Class III under the AMA Guidelines for impairment because of his severe obstructive disease. He said the Claimant was not capable of arduous manual labor.

Dr. Glen Baker examined the Claimant at the request of his counsel in connection with his state workers' compensation claim on November 6, 1995. DX 1 at 208. Dr. Baker is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 25 years. He reported a smoking history of "only 3-4 packs of cigarettes but has not smoked any beyond that." The chest examination was normal. Dr. Baker read the x-ray as showing pneumoconiosis, category 1/0. The pulmonary function test showed a moderately severe to severe obstructive ventilatory defect. The arterial blood gas study revealed moderate resting arterial hypoxemia. Dr. Baker diagnosed coal workers' pneumoconiosis, category 1/0, based on abnormal x-ray and significant duration of coal dust exposure; moderate resting arterial hypoxemia, based on the arterial blood gas analyses; chronic obstructive airway disease with moderately sever to severe obstructive ventilatory defect, based on pulmonary function testing, and chronic bronchitis, based on history. Dr. Baker said that the Claimant's disease was related to his work relationship, because the Claimant was "essentially a non-smoker and has 25 years of dust exposure with obstructive airway disease, chronic bronchitis, resting arterial hypoxemia and coal workers' pneumoconiosis. He has no other significant etiology for the condition that he has." DX 1 at 210. He indicated that the Claimant could not return to his coal mine employment or comparable work.

Dr. Gregory Fino reviewed the Claimant's medical records twice on behalf of the Employer in connection with the previous claim, and provided a reports dated January 17 and September 17, 1996. DX 1 at 200, 161. In his reports, Dr. Fino opined that the Claimant did not have pneumoconiosis. He found that the Claimant was disabled due to a severe respiratory condition caused by cigarette smoking. In the first report, Dr. Fino explained his reasons as follows:

1. The majority of chest x-ray readings are negative for pneumoconiosis.

2. The spirometric evaluations that have been performed show a pure obstructive ventilatory abnormality … in the absence of any restrictive defect. … In addition, the obstruction shows involvement in the small airways. … On a proportional basis, the small airway flow is more reduced than the large airway flow. This type of finding is not consistent with a coal dust related condition but is consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. …

3. This man shows improvement on the pulmonary function studies with bronchodilators. Reversibility following bronchodilators implies that the cause of the obstruction is not fixed and permanent. Certainly,

pneumoconiosis is a fixed condition. Because it is fixed, bronchodilator medication would be of no benefit. One cannot improve on an abnormality caused by coal workers' pneumoconiosis. Hence, improvement following bronchodilators showing reversibility to the overall pulmonary impairment is clearly evidence of a non-occupationally acquired pulmonary condition causing the obstruction.

4. He had a drop pO2, from 74 to 66, in four months time. This is far too rapid a drop to occur in a chronic condition like coal workers' pneumoconiosis. Changes in lung function or oxygenation take years to develop, not months. However, this type of change can be seen in someone with cigarette smoking induced lung disease. This type of change actually can be related to diurnal variation in blood gas measurements over time.

Coal workers' pneumoconiosis is an interstitial pulmonary condition. There is no evidence of an interstitial type of pulmonary condition in this case …

In this case, the degree of obstruction, the heavy smoking history, and the lack of findings of pneumoconiosis on the chest x-ray all point to a cigarette smoking etiology for this man's obstruction. I would not expect such severe obstruction to be present in a coal mine dust-induced lung condition in the absence of obvious coal workers' pneumoconiosis. There is no coal workers' pneumoconiosis in this particular case.

DX 1 at 205. Dr. Fino also provided x-ray interpretations on several different occasions, always reporting negative findings, reflected on the table above. Dr. Fino is board-certified in internal medicine and pulmonary disease, and a B reader.

Dr. Ben Branscomb also reviewed the Claimant's medical records on behalf of the Employer in connection with the previous claim, and provided a report dated June 4, 1996. DX 1 at 174 and 180.[8] Dr. Branscomb is a board-certified in internal medicine, and was a B reader at that time. Dr. Branscomb opined that the Claimant did not have coal workers' pneumoconiosis or any other occupational pulmonary disease, or any pulmonary impairment due to inhalation of coal dust. He said that the Claimant was 100% disabled as a result of severe chronic obstructive pulmonary disease caused by cigarette smoking. He based his conclusion on the fact that the Claimant had almost none of the characteristics of pneumoconiosis. He said the Claimant's exposure was confined to a relatively short period of truck driving, which represents a very small exposure, known in the medical literature and by his own observation. Dr. Branscomb stated that there was no medical or scientific basis to indicate that severe obstructive pulmonary disease is ever caused by minimal coal dust exposure or in x-ray negative pneumoconiosis. In contrast, the Claimant had all of the findings of non-occupational COPD with a history of severe cigarette smoking. His functional impairment was typical, with some reversibility, and the usual pattern of other symptoms. His physical examinations and negative x-rays were also consistent with COPD.

[8] The pages of the report became separated when they were numbered in connection with the processing of the current claim.

Dr. Mahmood Alam examined the Claimant on behalf of the Department of Labor on April 16, 2003, in connection with the current claim. DX 12. Dr. Alam's qualifications are not in the record and he is not listed on the web-site of the American Board of Medical Specialties.[9] He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines as a truck driver for 7 years. He reported a smoking history of "2 - 3 years quit many years ago & never had habit." The chest examination revealed wheezing on auscultation.. Dr. Alam diagnosed coal workers' pneumoconiosis based upon coal dust exposure. Additionally, he opined the Claimant suffers from severe respiratory impairment based upon the pulmonary function studies, chest x-ray, arterial blood gas studies and pneumoconiosis.

Dr. Alam prepared a report dated April 5, 2004, at the request of the Claimant's counsel. DX 15. In the report, he responded to specific questions relating to the black lung claim. He marked "yes" to the question whether the miner has a chronic lung disease caused by coal mine employment. He marked legal, but not clinical pneumoconiosis, elaborating that the Claimant has a history of tobacco abuse and approximately 15 years in mining. He said the Claimant quit smoking many rears ago, and still gets shortness [of breath] and chronic bronchitis. He indicated that coal dust made a significant contribution to the Claimant's condition. Asked to categorize the extent of the miner's pulmonary impairment, he marked "Totally Disabled." He indicated that the Claimant's pulmonary impairment was related to both coal dust and tobacco abuse. He checked "no" to the question whether the miner has the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. As his rationale, he mentioned the Claimant's pulmonary function test, chest x-ray and arterial blood gas results, and chronic pulmonary signs and symptoms. He indicated that he had not prescribed home oxygen, and that he had treated the miner over a three year period.[10]

Dr. David Rosenberg examined the Claimant on behalf of the Employer on October 27, 2003. DX 14. Dr. Rosenberg is board-certified in internal medicine, pulmonary disease, and occupational disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He also reviewed the report of Dr. Alam's examination, x-ray interpretations from Aril 1 and 16, 2003, and pulmonary function and arterial blood gas studies administered April 16, 2003. Dr. Rosenberg reported that the Claimant worked in the mines for 15 to 20 years. He reported the Claimant was a non-smoker throughout his life. The chest examination revealed "markedly diminished breath sounds, without rales, rhonchi or wheezes." Dr. Rosenberg read the x-ray as showing severe bullae formation with emphysema, mild pleural thickening, and no

[9] There are two doctors with the same name listed by the American Board of Medical Specialties, one of whom is board-certified in internal medicine, pulmonary disease, and critical care medicine, but he is identified as living in Scarsdale, New York. The other is a cardiologist.

[10] The earliest reference to treatment of the Claimant by Dr. Alam in evidence is a note in Dr. Bielecki's records indicating that Dr. Alam attended the Claimant in the hospital when he suffered from empyema in April 2001. Dr. Alam is identified as the requesting physician on several x-ray reports from the hospital during that period. There is nothing in the record indicating that Dr. Alam saw the Claimant during the year preceding his 2003 examination on behalf of the Department of Labor in violation of the prohibition found in 20 CFR § 725.406(b) (2006).

micronodularity associated with past coal dust exposure.[11] The pulmonary function test showed severe obstruction. The arterial blood gas study revealed hypoxemia at rest. No exercise study was administered because the Claimant had been told not to exercise by his physician. Dr. Rosenberg said that because the Claimant's total lung capacity was normal, he did not have restrictive disease. His lung fields were clear, and his x-ray demonstrated severe emphysema, but no micronodularity associated with past coal dust exposure. He concluded that the Claimant does not have the interstitial form of coal workers' pneumoconiosis. He said that the Claimant could not perform his previous coal mine job or similar job due to a severe oxygenation abnormality with severe airflow obstruction and a low diffusing capacity. He said the Claimant's disability related to his severe COPD. He said that coal dust exposure can cause COPD which begins in and around coal macules. He said that the Claimant's severe disabling COPD, not associated with simple or complicated nodules, did not relate to past inhalation of coal dust exposure. He went on to state, "Such disabling COPD with an FEV_1% as low as 44%, and [the Claimant's] roentgenographic findings, is something which I have not seen clinically occurring in relationship to coal mine exposure, or has been truly described in the medical literature." DX 14 at 4. He thought it probable that the Claimant's disabling COPD related to airway remodeling from advanced hyperactive airways.

Dr. Fino examined the Claimant and reviewed his medical records from both claims on behalf of the Employer on November 5, 2004. EX 1. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 15 years. Initially, he reported the Claimant was a non-smoker. However, based upon his review of the record, the Claimant had a significant smoking history of 1½ packs of cigarettes per day for 32 years, from 1960 to 1992. The chest examination was normal. He read the chest x-ray to be negative for pneumoconiosis, 0/0.[12] He said he agreed with Dr. Wiot's classification of the x-ray. He said that there was an infiltrate or chronic interstitial disease only in the right middle and lower zones. He said very significant emphysema was also present. The pulmonary function test showed moderate obstructive disease with no bronchodilator response. Lung volumes were elevated consistent with air trapping. Diffusing capacity was reduced. The arterial blood gas study revealed hypoxemia at rest and with exercise. Dr. Fino diagnosed significant and severe emphysema; chronic obstructive bronchitis with both fixed obstruction and reversible obstruction; severe impairment in oxygen transfer; and interstitial abnormalities in the right lung. He did not attribute any of these conditions to coal dust but did give an etiology of cigarette smoking. He said that the significant oxygen abnormalities do not go along with a 15-20 years history of working as a truck driver. He went on to state,

[11] It appears that Dr. Rosenberg relied on his own reading of the x-ray. The Employer did designate his x-ray reading as one on which it relied; rather, it designated a reading by Dr. Poulos. Dr. Rosenberg's reading of the x-ray is therefore not admissible. As he reviewed only two other x-ray interpretations, both of which were negative, however, the fact that one of the readings he relied on was inadmissible does not require that his opinion be discounted for that reason alone.

[12] It appears that Dr. Fino relied on his own reading of the x-ray. The Employer did designate his x-ray reading as one on which it relied; rather, it designated a reading by Dr. Wiot. Dr. Fino's reading of the x-ray is therefore not admissible. As he reviewed multiple x-ray readings from both claims, most of which were negative, however, the fact that one of the readings he relied on was inadmissible does not require that his opinion be discounted for that reason alone.

> Although coal mine dust can cause chronic obstructive pulmonary disease and emphysema, there are no clinical indicators in this case that coal mine dust has caused these disease processes. However, the clinical findings in this case are absolutely consistent with a smoking-related pulmonary condition.

EX 1 at 12. Overall, Dr. Fino opined that the Claimant does not suffer from pneumoconiosis but rather from a disabling respiratory impairment due to smoking, and that he does not retain the respiratory capacity to return to his previous coal mine employment or job of similar effort.

Total Pulmonary or Respiratory Disability

The Employer in this case has conceded that the Claimant is totally disabled by a pulmonary or respiratory impairment. This concession is well supported by the evidence in the record. A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. However, the pulmonary function tests, the weight of the arterial blood gas studies, and the unanimous medical opinion evidence dating back to 1995, all support a finding of disability in this case. In order to receive benefits, however, it is not enough for the Claimant to establish that he is totally disabled. Rather, he must establish that he is totally disabled *due to pneumoconiosis*.

Existence of Pneumoconiosis

> The regulations define pneumoconiosis broadly:
>
> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis,

anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease, chronic bronchitis, and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays, CT scans, and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

There are interpretations of 27 x-rays taken in connection with the Claimant's treatment between April 2001 and September 2004 in the record. None mention pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). In this case, none of the x-rays are entirely negative. Most refer to emphysema or pneumonia, and, more recently, several refer to interstitial changes. I find that the treatment x-rays are not negative for pneumoconiosis, but neither can they be considered to be positive.

Of the seven remaining available x-rays in this case, only the two earliest, both taken in 1995, read by an A and a B reader, have been read to be positive for pneumoconiosis. All of the remaining five x-rays, taken between November 1995 and November 2004, have been read by many dually qualified and B readers to be negative. I find that the more recent negative x-rays, read by better qualified readers, outweigh the two earlier positive readings. The Claimant therefore cannot establish the presence of pneumoconiosis based on the x-ray evidence.

The three CT scans taken in connection with the Claimant's treatment neither prove nor disprove a finding of pneumoconiosis. The first, taken in May 2001, showed pneumonia. The second, taken in January 2003, showed severe emphysema, and minimal interstitial fibrosis at the lung bases, with no focal pulmonary lesions. The most recent showed, emphysema, chronic interstitial changes and COPD. None of the readers mentioned pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion

may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that:

> … in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted).

The Department of Labor has taken the position that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. This underlying premise was stated explicitly in the commentary that accompanied the final version of the current regulations:

> … Whether coal mine dust exposure can cause chronic obstructive pulmonary disease is a question of medical and scientific fact that will not vary from case to case; thus, it is an appropriate question for the Department to answer by regulation. *See generally Peabody Coal Co.* v. *Spese*, 117 F.3d 1001, 1010 (7th Cir. 1997) (*en banc*); Davis, *Administrative Law Treatise*, § 6.7, 261–262 (3d ed. 1994). The revised definition will eliminate the need for litigation of this issue on a claim-by-claim basis, and render invalid as inconsistent with the regulations medical opinions which categorically exclude obstructive lung disorders from occupationally-related pathologies. The Department reiterates, however, that the revised definition does not alter the former regulations' (20 CFR 718.202(a)(4), 718.203 (1999)) requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source. …

65 Fed. Reg. at 79938. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." Ibid. I have considered how to weigh the conflicting medical opinions in this case based on these principles.

Both the history of the Claimant's work in the mines, and his smoking history, are critical factors in weighing the medical opinions regarding the etiology of the his lung impairment. As to his work history, doctors' reports reflect from 7 to 36 years of coal mine employment. I have found 11. In addition, the Claimant has given a varied smoking history to the doctors who have treated or examined him over the years. In July 1995, he told Dr. Fritzhand that he smoked 1 – 1 1/2 packs per day from 1960 to 1992. In August 1995, he gave a very similar history to Dr. Bielecki, *i.e.*, that he smoked a pack and a half of cigarettes per day from the age of 17 to the age of 50, quitting 3 or 4 years before the examination, that is, in 1991 or 1992. Both accounts would amount to over a 40 pack year smoking history. In October, 1995, however, he gave a very different smoking history to Dr. Baker and Dr. Myers, who examined him in connection with his state and federal black lung claims, saying he only smoked for a few years as a teenager, and never got the habit. He gave a similar history to Dr. Alam and Dr. Rosenberg in 2003, and offered similar testimony at the 2006 hearing. I find that the later version of his smoking history lacks credibility. In reaching this determination, I considered the close similarity between the histories recounted by Drs. Fritzhand and Bielecki, suggesting that their records were not the result of mistake or misunderstanding on their part of what he told them; the fact that what the Claimant said about his smoking history changed during the period his state and federal black lung claims were being processed; the fact that the records of the doctors who were told the later version were similar to each others', again suggesting no mistake or misunderstanding on their part; the similarity of the Claimant's wording, over a period of ten years, that he "never had the habit" of smoking; and the Claimant's demeanor when testifying at hearing. I also found it to be significant that the Claimant was angry with Dr. Bielecki for disclosing his smoking history after he was notified that his federal black lung claim had been denied at the initial level. I infer from the sequence of events that at some time between August and October 1995, the Claimant came to believe that truthfully disclosing his smoking history might adversely affect his claim, leading him to minimize his smoking history. Contrary to the minimal smoking history to which the Claimant admitted beginning in October 1995, I find that the Claimant has at least a 40 pack year history of smoking.

Turning to the medical opinion evidence regarding the etiology of the Claimant's pulmonary disability, I must consider each opinion and the basis for it in reaching my conclusion

whether the Claimant has met his burden to show that his pulmonary disability is due to pneumoconiosis.

Dr. Bielecki has been the Claimant's treating physician for over ten years. She specializes in family practice. Her initial assessment of the Claimant in August 1995 was that he had "possible black lung." Thereafter, however, she consistently assessed COPD, emphysema and chronic bronchitis, as well as periodic episodes of pneumonia, and eventually, chronic hypoxia, without further reference relating to coal workers' pneumoconiosis, except for January 27, 1997, when she referred to his "known pneumoconiosis," and October 21, 2003, when she referred to "significant coal mine exposure." However, Dr. Bielecki never made a definitive diagnosis of pneumoconiosis herself, or explained how his pneumoconiosis was "known." Her March 11, 2003, note suggests that she relied on Dr. Alam to treat the Claimant's lung condition in recent years. I do not find her records to be probative on the issue of whether the Claimant has pneumoconiosis.

Dr. Alam has been the Claimant's treating physician, at least on an episodic basis, since 2001. Dr. Alam also conducted the Claimant's pulmonary evaluation on behalf of the Department of Labor in 2003, and submitted an additional report supporting the claim for benefits. Dr. Alam's qualifications are not in the record, and he is not listed on the website of the American Board of Medical Specialties, so his qualifications cannot be determined. Reading Dr. Alam's reports together, it appears that the Claimant never told him about his complete smoking history. Rather, Dr. Alam believed that the Claimant smoked only for two to three years. *See* DX 12. He believed that the Claimant had 15 years of coal mine employment. *See* DX 15. Dr. Alam diagnosed legal pneumoconiosis which he attributed to both smoking and coal dust exposure. As a treating physician, Dr. Alam's opinion would be entitled to substantial weight on this issue, but for the fact that he was not aware of the Claimant's actual smoking history. It is impossible to know on the record before me whether his opinion would have been the same had he been fully informed of a history of 11 years of coal mine employment, and a 40 pack year smoking history.

Dr. Fritzhand examined the Claimant in July 1995. He is board certified in urology. He has no documented specialist qualifications relevant to diagnosing lung disease. He initially diagnosed COPD and pneumoconiosis, based on a 30-45 pack year history of smoking, and 30 years of coal mine employment. When advised that the Department of Labor had verified only 3+ years of coal mine employment, however, he changed his opinion, and attributed all of the Claimant's symptoms and signs to smoking. The way his opinion is worded suggests that he did not subscribe to the premises underlying the current regulations, that exposure to coal dust can cause COPD. In any event, Dr. Fritzhand's opinion does not support the conclusion that the Claimant has pneumoconiosis.

Dr. Myers diagnosed pneumoconiosis based on a positive x-ray reading, and on his view that there was no other obvious source for the Claimant's pulmonary disease. Dr. Myers' opinion is based the Claimant's misrepresentation that he was essentially a non smoker. His diagnosis is also undermined by the fact that he relied on a positive x-ray reading, while I have found the more probative x-rays to be negative. In addition, Dr. Myers thought the Claimant had 36 years of coal mine employment, while I have found only 11. All of these factors render his opinion unreliable.

Dr. Baker's opinion suffers from similar shortcomings. Dr. Baker is a pulmonologist, and thus well qualified to render an opinion. However, Dr. Baker thought the Claimant had 25 years of coal mine employment, and no significant smoking history. He, too, relied in part on a positive x-ray, while I have found the weight of the x-ray evidence to be negative for clinical pneumoconiosis. He, too, diagnosed pneumoconiosis because he was not aware of any other significant etiology than coal mine work. Because he was misinformed about the Claimant's smoking history, I do not find that his opinion supports a finding that the Claimant has pneumoconiosis, either.

Drs. Alam, Myers, and Baker are the only physicians who provided documented and reasoned opinions that the Claimant has pneumoconiosis. Their opinions, however, were based on inaccurate and incomplete information. Dr. Bielecki apparently also believes that the Claimant has pneumoconiosis, but her opinion is not documented or reasoned. Dr. Fritzhand initially believed that the Claimant had pneumoconiosis, but changed his opinion when he learned that the Claimant had significantly fewer years of coal dust exposure than he originally believed. Considering all of the medical opinion evidence which could support the Claimant's case, I find that the Claimant has failed to carry his burden of proving that he has pneumoconiosis. Because the opinions of Drs. Alam, Myers and Baker are insufficient to carry the Claimant's burden of proof on this issue, I need not address the weight to be accorded the opinions of Drs. Fino, Branscomb and Rosenberg, all of whom attributed the Claimant's pulmonary disability to factors other than coal mine dust exposure.

Neither the x-ray evidence, the CT scan evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal mine dust. Thus he cannot show that he is entitled to benefits under the Act.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that his pulmonary disease is due to pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by the Claimant on February 12, 2003, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).